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BOARD OF ADMINISTRATION

PENSION & HEALTH BENEFITS COMMITTEE

OPEN SESSION

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JAMES F. PETERS, CSR
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A P P E A R A N C E S

COMMITTEE MEMBERS:

Ms. Priya Mathur, Chairperson

Mr. Michael Bilbrey, Vice Chairperson

Mr. John Chiang, represented by Mr. Grant Boyken

Mr. Rob Feckner

Mr. Richard Gillihan

Mr. J.J. Jelincic

Mr. Henry Jones

Ms. Theresa Taylor

Ms. Betty Yee

BOARD MEMBERS:

Mr. Richard Costigan

Ms. Dana Hollinger

Mr. Ron Lind

Mr. Bill Slaton

STAFF:

Ms. Anne Stausboll, Chief Executive Officer

Ms. Ann Boynton, Deputy Executive Officer

Mr. Matt Jacobs, General Counsel

Mr. Danny Brown, Chief, Legislative Affairs Division

Ms. Jennifer Jimenez, Committee Secretary

Mr. Doug McKeever, Chief, Health Policy Research Division

A P P E A R A N C E S C O N T I N U E D

ALSO PRESENT:

Ms. Sara Flocks, California Labor Federation

Mr. Neal Johnson, Service Employees International Union, Local 1000

Mr. George Linn, Retired Public Employees Association

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P R O C E E D I N G S

CHAIRPERSON MATHUR: All right. Could afternoon, everyone. We're going to get started. This is the Pension and Health Benefits Committee. First order of business is roll call.

COMMITTEE SECRETARY JIMENEZ: Priya Mathur?

CHAIRPERSON MATHUR: Good afternoon.

COMMITTEE SECRETARY JIMENEZ: Michael Bilbrey?

VICE CHAIRPERSON BILBREY: Here.

COMMITTEE SECRETARY JIMENEZ: Grant Boyken for John Chiang?

ACTING COMMITTEE MEMBER BOYKEN: Here.

COMMITTEE SECRETARY JIMENEZ: Rob Feckner?

COMMITTEE MEMBER FECKNER: Good afternoon.

COMMITTEE SECRETARY JIMENEZ: Richard Gillihan?

COMMITTEE MEMBER GILLIHAN: Here.

COMMITTEE SECRETARY JIMENEZ: J.J. Jelincic?

COMMITTEE MEMBER JELINCIC: Here, but I think starting on time is a violation of policy.

COMMITTEE SECRETARY JIMENEZ: Henry Jones?

COMMITTEE MEMBER JONES: Here.

COMMITTEE SECRETARY JIMENEZ: Theresa Taylor?

COMMITTEE MEMBER TAYLOR: Here.

COMMITTEE SECRETARY JIMENEZ: Betty Yee.

COMMITTEE MEMBER YEE: Here.

CHAIRPERSON MATHUR: And please also note for the record that Mr. Lind, Mr. Costigan, Mr. Slaton and Ms. Hollinger are in attendance as well.

The next order of business is the executive report.

Ms. Boynton.

DEPUTY EXECUTIVE OFFICER BOYNTON: Good afternoon, madam Chair and Committee members. Today, you will consider the approval of health plan premiums for 2016 and a change in how Medicare Advantage is offered to our members. Staff has worked with our plans over several very challenging months to ensure that rates are as low as possible. Still, there is no doubt that the proposed premiums are higher than we would like them to be.

The health care delivery landscape is complex, and achieving fundamental change in the industry is a long-term proposition. There are promising changes underway and we believe that these will help create sustainable revision. Given CalPERS strength in the marketplace, staff is involved in a variety of activities, boards, and committees that are looking at these questions through numerous lenses, including federal and State payment reform, pharmacy cost issues, physician quality projects, aligning our efforts related to quality and payment with the Department of Health Care Services and

Covered California, participating in a State work group to tackle high cost drug pricing, and engaging with plans and providers on reducing overused and nonvalue-add services.

Just a side note that on the Medicare payment reform front we are participating in the recently established health care payment learning and action network, which is focused on Medicare and Medicaid payment reform. And I've been appointed to the national guiding committee for that effort. We are also looking at how we might expand the use of palliative care beyond hospice benefits.

We take very seriously the charge to reduce the cost of health care and want to assure the Committee that we are actively engaged at the State and national levels on behalf of our employers and members.

This concludes my report.

CHAIRPERSON MATHUR: Thank you. Any questions from the Committee?

I see none.

Agenda Item number 3 is the action consent item, approval of the May 19th, 2015 meeting minutes. What's the pleasure of the Committee?

COMMITTEE MEMBER JONES: Move approval.

CHAIRPERSON MATHUR: Moved by Mr. Jones.

VICE CHAIRPERSON BILBREY: Second.

CHAIRPERSON MATHUR: Seconded by Mr. Bilbrey.

On the motion?

Mr. Jelincic.

COMMITTEE MEMBER JELINCIC: Yeah, there is an error at the end on the speakers in public comment, Gary Collier happens to be a member of the State Retirees, but was speaking as a CalPERS member, not speaking on behalf of the organization.

DEPUTY EXECUTIVE OFFICER BOYNTON: We will make that change.

CHAIRPERSON MATHUR: Okay. Thank you.

So with that one edit, on the motion, all those in favor?

(Ayes.)

CHAIRPERSON MATHUR: All opposed?

Motion passes.

Move on to Agenda Item number is the consent items. I've seen no other consent items to be brought forward. Agenda item, number 5 is Legislation. Mr. Brown.

LEGISLATIVE AFFAIRS DIVISION CHIEF BROWN: Good afternoon, Madam Chair and Committee members. Danny Brown, CalPERS staff. This first agenda item, SB 546 by Senator Leno does three things.

First, it establishes a rate review process for

health plans and health insurers that provide coverage in the large group market. It requires health plans to submit rate information to the Department of Health Care, if the rate increase meets one of the two triggers for rate review. The triggers are rate increases greater than 150 percent of the average rate increase for its large group plans, or the rate increase would cause the health plans for the large group purchaser to incur the excise tax for any part of the period the rate increase is proposed to be in effect.

It allows DMHC to review and make determination as to whether the increase is reasonable or unreasonable. The bill also modifies existing annual reporting requirements for health plans to file specified aggregate data for all plans and policies that sell in the large group market.

And then finally, the bill requires health plans in their notice to large group purchasers to include information on whether the rate increase exceeds the average rate increase for Covered California or CalPERS, or whether the rate increase triggers the excise tax. These last two provisions don't specifically impact CalPERS. However, consistent with the Board's legislative policy standards, you can state that they do support transparency and accountability.

It's the rate review provision that you'll notice that our agenda item kind of focused on, and this is the one area that staff has discussed with you before and has concerns with. The rate review provision would allow DMHC to review the prosed rate increases from CalPERS contracted HMO plans, which the Board has negotiated and adopted.

Thus, the determination as to whether CalPERS health rates are reasonable or unreasonable would not be helpful to CalPERS rate-setting process nor would the timing allow for any adjustments without interrupting the open enrollment period.

Staff believes this type of review of the rates CalPERS has negotiated and set is unnecessary and does not provide any extra value. Therefore, staff is recommending a support, if amended, position with the amendment being to exempt CalPERS from the rate review process.

CHAIRPERSON MATHUR: Thank you. We have a couple of questions.

Ms. Taylor.

COMMITTEE MEMBER TAYLOR: So, yeah, I just wanted to know, you had said that it adds no value, and that it doesn't help with our transparency. So what do you mean by that? Can you explain that a little better for me?

LEGISLATIVE AFFAIRS DIVISION CHIEF BROWN: Well,

I think on the transparency piece, I was talking about the data. One of the pieces is requiring health plans to report aggregated data to DMHC. Most of that -- or all of that information CalPERS is already receiving. So having that information go to DMHC doesn't necessarily benefit us. It may benefit other large purchasers that may want to access that data. But from our standpoint, that wasn't something that, you know, we could probably -- you know, was a big issue for us. So it was more of the rate review component that we kind of concentrated on. And the concern is since the Board has already negotiated adopted rates, have the data they need to make that decision, it's not like DMHC is going to get any additional data that the Board hasn't already seen, and they're going to be able to look at something that we hadn't looked at.

COMMITTEE MEMBER TAYLOR: Okay. Great. That's what I was trying to clarify. Thank you.

CHAIRPERSON MATHUR: Thank you. Mr. Jones.

COMMITTEE MEMBER JONES: Yes. Thank you, Madam Chair. I move the approval of this recommendation.

CHAIRPERSON MATHUR: Thank you. Is there a second?

ACTING COMMITTEE MEMBER BOYKEN: Second.

CHAIRPERSON MATHUR: Moved by Jones, seconded by Boyken. I -- oh, Mr. Jelincic, on the motion.

COMMITTEE MEMBER JELINCIC: What's the status of the bill?

LEGISLATIVE AFFAIRS DIVISION CHIEF BROWN: The bill has passed out of the first House, and so it will be heard in the Assembly Health Committee sometime this month.

COMMITTEE MEMBER JELINCIC: Thank you.

CHAIRPERSON MATHUR: Ms. Yee.

COMMITTEE MEMBER YEE: Thank you, Madam Chair.

I just had a question, because -- and I support the staff recommendation, but it does beg the question as to the availability of some of the data that we do receive, and whether any of that is subject to public disclosure upon request. I'm just kind of curious. I mean, to the extent that our negotiations are not -- are confidential, but what about the data itself?

DEPUTY EXECUTIVE OFFICER BOYNTON: The information that we receive from our plans is confidential and is not releasable to the public.

COMMITTEE MEMBER YEE: Okay. All right. Thank you.

CHAIRPERSON MATHUR: Thank you. I do have a couple of requests to speak. They've put down 5b, but I think you might mean 5a. Neal Johnson and Sara Flocks, did you want to speak on this item or did you really

mean --

MR. JOHNSON: 5b.

CHAIRPERSON MATHUR: Okay. You meant 5b. Okay. You meant 5b or did you want to speak --

MS. FLOCKS: 5a.

CHAIRPERSON MATHUR: 5a. Come on down, Ms. Flocks. And if you could, identify yourself and your affiliation for the record. You will have three minutes, at which time actually the mics will turn off.

MS. FLOCKS: Thank you, Madam Chair, Board members. Sara Flocks. I'm from the California Labor Federation. We are the co-sponsors of SB 546, Leno. And I would like to thank the staff for their recommendation to the Board. We represent a number of large purchasers. And as with CalPERS, the increasing cost of health care is an extreme concern of ours, an urgent pressing concern.

And this bill we think will increase transparency. We think in one regard it will be helpful in CalPERS in that it will give us a view of how the entire large group market is working. So having this information on all of the products in the market will be useful.

And I also wanted to say that I do understand that CalPERS wants to be exempted. We understand that there are certain purchasers in the market that do have a

large amount of purchasing power, and we respect that, and we're looking at amendments that will accommodate that fact. So thank you.

CHAIRPERSON MATHUR: Thank you very much for your comments.

Ms. Yee.

COMMITTEE MEMBER YEE: Oh, I'm sorry.

CHAIRPERSON MATHUR: Okay. I see no further requests to speak. So on the motion, all those in favor say aye?

(Ayes.)

CHAIRPERSON MATHUR: All those opposed?

Any abstentions?

COMMITTEE MEMBER GILLIHAN: Yes.

CHAIRPERSON MATHUR: Please note CalHR's abstention.

Move on to Agenda Item number 5b, Senate Bill 275.

LEGISLATIVE AFFAIRS DIVISION CHIEF BROWN: Okay. Senate Bill 275 by Senator Hernandez deals with health facility data. Currently, hospitals and surgical clinics are required to submit patient demographic and encounter data on hospital discharges, emergency care, and surgery to the Office of Statewide Health Planning and Development.

However, this data does not include physician identifiers. The Bill would require OSHPD to adopt a regulation adding physician identifiers to these reports. And I just want to kind of stop point -- stop there and kind of point that out, that this is going to just give them the authority to adopt regulations. So there will be a transparent process to promulgate those regulations that some of the opponents could then, you know, be involved in to address their concerns.

In 2001, the Board supported Senate Bill 680, which required OSHPD to publish annual risk-adjusted outcome reports for coronary artery bypass graft surgeries, and to include individual physician data where appropriate. As of 2011, the operative mortality rate for isolated coronary artery bypass graft surgery in California fell by 31 percent since 2003, the first year of the mandated reporting.

The coronary artery bypass graft report is the only one required to contain individual physician data. So adding physician identifiers to the other reports that OSHPD puts out will only provide CalPERS members more detailed information about health care outcomes. It will also enable them to compare the performance of potential treating hospitals, physicians, and surgeons and select appropriate providers on the basis of quality of care and

not just cost.

Therefore, staff is recommending a support position.

CHAIRPERSON MATHUR: Thank you. On the item?

COMMITTEE MEMBER JELINCIC: Move it.

CHAIRPERSON MATHUR: Moved by Mr. Jelincic.

Is there a second?

COMMITTEE MEMBER JONES: Second.

CHAIRPERSON MATHUR: Seconded by Mr. Jones.

We do have someone from the public who wishes to speak. Mr. Johnson.

MR. JOHNSON: Good afternoon. Neal Johnson. I'm with Service Employees International Local 1000. I encourage the Board to take a support position on this bill. I'm actually one of those who's been a beneficiary of the CABG legislation, and happen to, a little bit of the luck of the draw, have a surgeon that was ranked in 2006 as the top 2 in California perform my surgery, which is probably why I'm still here --

(Laughter.)

MR. JOHNSON: -- because they -- apparently the betting in the operating room is I wouldn't survive through it.

But more seriously, we really -- we have always supported increasing data collection and transparency, and

here is another opportunity where California can move forward with better data collection on -- and identify physicians doing procedures and, as Mr. Brown said, simply directs OSHPD to develop regulations. And through that process the opponents will have their opportunity to raise what they view as problems, and potentially will also lead to eventually not just the providers but the whole train of -- or not just physicians but that whole train of providers on various procedures.

So we view this as a first step in what still needs to be done. Anyway, we encourage you to take a support position. Thank you.

CHAIRPERSON MATHUR: Thank you very much for your comments, Mr. Johnson.

On the motion, all those in favor?

(Ayes.)

CHAIRPERSON MATHUR: All those opposed?

Any abstentions?

COMMITTEE MEMBER GILLIHAN: Yes.

CHAIRPERSON MATHUR: Please note CalHR's abstention.

We do have a couple of requests to speak, Mr. Brown, before you leave. Mr. Feckner.

COMMITTEE MEMBER FECKNER: Thank you, Madam Chair. Mr. Brown, through the Chair, I'd like to ask that

in August that we agendize SB 588 whether that be this Committee or the full Board, please, so we can get an update.

Thank you.

LEGISLATIVE AFFAIRS DIVISION CHIEF BROWN: Yes, I'll do that.

CHAIRPERSON MATHUR: That will be the order.

Mr. Jelincic.

COMMITTEE MEMBER JELINCIC: And, Danny, I would like to -- it was a consent item, and I didn't want to pull them, but I would like to point to the Avenue Solutions and Jennings Policy Strategy presentation. I thought it was really very effective in that it said this is the issue, this is the implications for CalPERS, this is the next step. So I would like to commend them on that, and would like to encourage you to make sure the other consultants see it. And they may want to think about adopting that solution.

Thank you.

CHAIRPERSON MATHUR: Thank you.

Well, the next items are the ones we've been waiting for. Agenda Item number 6 is approval of the 2016 HMO plan premiums.

HEALTH POLICY RESEARCH DIVISION CHIEF McKEEVER:

Good afternoon, Madam Chair, members of the

Committee. Doug McKeever, CalPERS staff. If you don't mind, I'm going to get a little comfortable. I think I'm going to be here awhile.

CHAIRPERSON MATHUR: Please do.

(Laughter.)

HEALTH POLICY RESEARCH DIVISION CHIEF McKEEVER: So this year's rate-setting process has been challenging for CalPERS, as Ms. Boynton mentioned. First, the market dynamics have shifted from where we saw modest year-over-year increases to one where health care costs have risen more sharply. There are several factors contributing to this. And I want to point back to a report that we provided the Committee back in April on our trend report, in which we were able to share with you some of those rising costs during the fiscal year 13-14 in which hospital costs were contributing an increase of about five percent.

And then the second, and more concerning, was in the rise of pharmacy costs. Our April trend report reflected pharmacy costs going up almost 10 percent for that fiscal year. Obviously, these increases played a great role in determining the 2016 proposed rates before you today. I think it's helpful also to offer a bit perspective, in that CalPERS is not alone in this particular situation.

And I want to share with you just the excerpts of three very recent articles that highlight that. The first is back on June the 8th, and the tag line the, "*Specialty Drugs Drove Upward Surge in Pharma Spending Last Year*". And the essence of the article is that spending on drugs rose 13 percent in '14 from the prior year. However, specialty drugs were responsible for much of the increase as costs in that category increased over 20 percent last year.

The second and more recent article came out on June the 10th with the tag line, "*Two New Cholesterol Drugs Raise Questions of Cost And Access*". And this is in relation to the FDA advisory panels that recently recommend approval of two drugs that may significantly lower cholesterol.

"Experts warn the potential high cost for these blockbuster drugs could limit their access and once again raise concerns about sky-rocketing prescription drugs. A new report released Tuesday projects PCSK9 inhibitors...", and that's what these drugs are for cholesterol, "...could cost the U.S. health system up to 23 billion annually".

And then finally, on June 11th, "*Hospital Sector Pushes Health Care Spending Growth Over Seven Percen*t". And this is out of the Census Bureau's quarterly services survey considered one of the more accurate depictions of

the U.S. economy showed health care spending went up 7.2 percent in the first quarter of this year compared with the same period of '14.

Again, just a few examples of many that are out there that are highlighting how the market dynamics have shifted from where they were several years ago to some of the challenges that CalPERS and others are facing today.

In addition, we included in the agenda item, a list of our top 10 drugs for CVS, Blue Shield, and for Kaiser for the 2014 calendar year. I'm not going to go over these in detail this afternoon, but it was again provided for some context relative to what those drugs are, how much they cost, and then the percent that it equals for our total pharmacy spend for each one of those PBMs. And again, you'll notice that it's significant when it comes to those top 10 drugs.

And then finally, a general observation for '16 rates needs to address the increases for the Blue Shield NetValue plan for the second year. Pricing challenges began back in 2014 for the NetValue product when we introduced competition into the CalPERS program. And those pricing strategies for the NetValue product fell short of the true cost experienced by that plan.

This was further complicated as rates for 2015 came in very high and generated and exited of over 50,000

Blue Shield members from their plans, of which 48,000 of those came out of the NetValue product. This exit placed an even greater challenge on the NetValue plan, which contributed greatly to the increases that you see today for 2016 for NetValue.

Fortunately, there are competitive priced options available to our members. We are encouraging our employers and our employees to take the time to identify the options that will be available to them in 2016, and pay particular attention to the open enrollment materials in order to make the best decision for them.

I do want to note that Blue Shield and CalPERS are strongly committed to correcting this before we launch the 2017 rate-setting process, and we will begin those discussions shortly.

Finally, on the regional side, there's a mixed bag. And if you live in the Bay Area tonight, there may be great cause for celebration if the Warriors pull out the finals. But if you're a contracting agency member, the actual regional rates for the Bay Area are not so good.

And so we want to make reference to the fact that we also recognize that this puts additional pressures on our employers and our members, and we will be looking in the coming years to see whether or not there are

opportunities for us to address these significant regional variations and costs, specifically as they relate to those that are in the north versus those in the south.

In summary, we're not overly pleased with the rate increases, and we recognize the additional cost pressures any increase puts on our members and our employers. Although, we consider ourselves a sophisticated purchaser, and one that strongly encourages and develops innovative programs and payment models, we are also not content or accepting of the current state.

We will continue to be vigilant and push our health plan partners to challenge the provider community to lower their costs and continue to work on efforts to address the rising costs of health care overall.

The second challenge, and one that addresses Medicare, was to seek an alternative approach to our current Medicare plan offerings. To that end, we requested our health plans to provide us with options that we could consider on a non-Kaiser single Medicare approach, which we discussed in detail last month at this Committee.

Based on your direction, today's HMO rate proposal includes two alternatives for your consideration. Alternative number 1, our proposed 2016 HMO risk-adjusted rates for Anthem, Blue Shield, Health Net, Kaiser, Sharp

and United, with United Healthcare as the single non-Kaiser Medicare carrier, or Alternative 2, our proposed risk-adjusted rates for all the plans, yet keeping the Medicare program as it is today.

The 2016 proposed rates for Alternative 1 are reflected in Attachment 1, and proposed rates for Alternative 2 are reflected in Attachment 2. I do want to call out one very minor error that we made in the agenda item on page two of seven and three of seven, where we said PERS Select under the Anthem category. That should read Anthem Select, not PERS Select.

So, Madam Chair, what I'd like to do now is go over what are inclusive of the rates by plan for Alternative number 1. For Anthem Blue Cross, there is the addition of Welvie, which is an on-line tool that helps educate the member and place more power in their hands when it comes to minimizing unnecessary and inappropriate surgeries. That will be available on the basic plan.

Anthem Select will be expanding into San Diego County on the basic plan.

For Blue Shield of California, they will also be including Welvie as part of their basic plan. They will also have an enhanced prescription drug benefit with 90-day supply option, giving members the option to fill their prescriptions at select retail pharmacies when mail

service by PrimeMail is not feasible or desired for the basic plan.

For Health Net, they're expanding into 16 counties that are reflected in the agenda item. I'm not going to read all of those, but I will tell you that they're all up north, so they're expanding greatly into the Northern California basin. This will bring the total of counties served by Health Net to 21.

For Kaiser, we had to standardize the acupuncture and chiropractic benefit that you all approved last year to ensure that the $15 co-pay with the combined 20 visits applied to the Medicare product as well.

For UniteHealthcare, they will have their United Alliance HMO expand into San Diego County, Kings, and Marin. They will also be the single HMO non-Kaiser Medicare provider. And then in addition to that, there's been an addition since May, which would add a benefit of a 90-day supply option at select participating retail pharmacies at the mail order price for maintenance medications only.

So what I'd like to do now is spend a little bit of time just highlighting the UnitedHealthcare Medicare Advantage PPO plan. And I know I covered this last month, but I think it's worth again repeating what the plan offerings are in Alternative number 1.

So this particular plan has national coverage. It is provided in all 58 counties in California, as all of the entire U.S., and the five U.S. territories. So basically the plan travels with the member.

It provides the same benefits, regardless of network. Any provider accepting Medicare will accept this plan. If a non-contracting provider seeks monies from members up front, United will reimburse the member minus the co-pay. There was a question that came up last month relative to how often that occurs, and whether a maybe will actually be asked to pay up front. And according to United when they did their analysis on this, less than one percent of their members nationally are requested to make such an upfront payment.

There is no referral required to see a specialist, and there's no PCP, primary care physician, required. There is the addition of what's called house calls and a highly popular and enthusiastically received program called SilverSneakers, which will be available in this program.

There is complete coordination between medical and pharmacy with the benefit. And there will be one single plan ID card. They have a national pharmacy network with over 65,000 retail locations.

Preventative services are fully covered with no

additional cost. And then something for our contracting agency Medicare members who currently do not have access to either vision or dental benefits, there will be an option for them to directly contract and pay for those benefits with UnitedHealthcare.

There is no employer cost to this, as the member is fully responsible for the cost of that particular benefit.

To give you the final premium for the UnitedHealthcare Medicare proposal for 2016, as articulated in the attachment, the premium is $320.98. I do want to note that for those contracting agency members who do in fact request the optional dental and vision benefit, there will be an additional cost to them of $26.32 per member, per month. So obviously, if there's more than one member, then that will go up accordingly.

So folks can figure out that that $26.32 added to the 320 would roughly be 347, if a contracting agency Medicare retiree wanted those two additional benefits.

As mentioned, there are to alternatives presented. Alternative 1 presents the HMO rates if the Board approves the United approach. And Alternative 2 presents those rates with no change. I think it's important to note what those differences look like between the Medicare premiums of Alternative 1 and Alternative 2.

And then I will share with you what the projected savings are as a result.

So for 2016, if we stayed the status quo, for Anthem, Blue Shield, and Health Net, there would actually be a higher premium attributed to those Medicare plans than the UnitedHealthcare single Medicare offering. As an example, for Anthem, the difference is $170 and some change, and for Health Net it's as low as $3.80. It's also worthy to note that Kaiser, both for its in-state and out-of-state, Sharp and United, have a lower price of roughly $23 to $26 over the United product.

Looking at the estimated savings, and given that the Blue Shield current Medicare plan contains most of our HMO non-Kaiser members, of which there are over 40,000, Blue Shield has the majority of those members today. So we looked at the difference between the single carrier approach and the Blue Shield suggested rate status quo, in which there's about a $50 difference, and we calculated out that as -- if all of those members moved to the United single Medicare approach, there would be an annual savings of roughly $24 million.

We also thought it was appropriate, given that there may be many, many of our Medicare members who are currently in our PPO products, that find this attractive as well. And given the fact that our PPO product Medicare

rates will be higher than the United single Medicare rate, if, in the best case scenario, all 51,000 Medicare members in PERSCare moved, there would be about $53 million savings.

Using the same analysis for PERS Select and PERS Choice, of which there are 63,000 members, the potential savings there would be 34 million, if all of them moved. Now, obviously, they're not all going to move, but it just gives you some context relative to the potential savings opportunities that there are out there for our members and our employers.

Finally, we have actively engaged the retiree stakeholders from the very beginning of this process. We held our first meeting on May 1st, a second meeting was held on May the 14th, and our third meeting was recently held on June the 11th. The focus of the last meeting was mostly a reinforcement of what we already provided them. Then we spent a lot of time on process and communication efforts that would need to take place if the Board were to approve this approach.

I do want to take a point of personal privilege to say thank you very much to our stakeholders for their active and candid engagement in this process, and to our Stakeholder Relations team, primarily David Teykaerts for coordination and facilitation of the meetings, along with

being the point person of contact, roughly so I wouldn't have to be, for all of the emails that came in seeking guidance and asking questions about this particular plan approach.

The final thing I want to note on this is in May we indicated that if this approach were approved, there is a small number of CalPERS members who currently reside in, what we call, a combination plan in which there is one member in basic and one member in Medicare. Right now there are roughly 15,000 total members who are in a combo plan, of which 8,000 of those are in a basic plan. We ran the analysis recently with the addition of Marin and Kings County that United will be moving into, if you choose this approach. And we've now determined that there will be less than 3,000 members, roughly 2,700 who, in fact, will not have an option of a United basic plan to move into. And therefore, they, and their dependent or spouse who is in Medicare, would most likely need to seek-out services through our PPO.

Obviously, depending upon where they are in their basic plan and the age that they are, they certainly, once they become Medicare age eligible, could have the choice then to move out of that PPO product if they so chose into another alternative that would be available to them, either Kaiser or the United single Medicare approach.

Lastly, we do have some out-of-state members, roughly 1,800 that are in Kaiser. I do commend Kaiser for their ability to look at their out-of-state and in-state medicare rate, and you'll notice in the proposal that they are the same, so most likely the out-of-state members who are currently with Kaiser will remain in Kaiser, but we do have 30,000 out-of-state members in our PPO that might also find this particular approach extremely attractive.

Madam Chair, moving to Alternative number 2, I want to highlight the difference, rather than repeat what is contained within, because most of the things that I read in Alternative 1 are contained in Alternative 2 with the few minor exceptions that I would like to cover.

The first for United, they would actually not be able to expand into Kings and Marin County, if they were not selected as the single Medicare choice. That roughly is because of the fact that they're not able to put a Medicaid Advantage product in those two counties, so they wouldn't be able to expand into those two counties.

And then obviously, but worth repeating, is the fact that Alternative 2 would allow the other carriers to keep their Medicare plans. And many of our plans would look to expand their Medicare Advantage plans into areas now where they might have a supplement product. So in the agenda item under Alternative 2, each plan will show which

ones would look to have a Medicare Advantage Plan expansion.

So I think, Madam Chair, this is a good time to pause and be able to address any questions that you all may have relative to Alternative 1 and Alternative 2.

CHAIRPERSON MATHUR: Thank you. Are there any questions from the Committee?

We have a couple questions from the Committee.

Mr. Jelincic.

COMMITTEE MEMBER JELINCIC: In Alternative 1, the UnitedHealthcare, the 90-day supply for prescriptions, that applies to both basic and Medicare, correct?

HEALTH POLICY RESEARCH DIVISION CHIEF McKEEVER:

No, Mr. Jelincic. That is specific to the single Medicare product offering only.

COMMITTEE MEMBER JELINCIC: Okay, because the agenda item doesn't make that clear, and on the web you may want to insert a little note --

HEALTH POLICY RESEARCH DIVISION CHIEF McKEEVER:

Okay. Thank you.

COMMITTEE MEMBER JELINCIC: -- that it's Medicare only.

CHAIRPERSON MATHUR: Thank you.

Mr. Gillihan.

COMMITTEE MEMBER GILLIHAN: Thank you, Madam

Chair.

Doug, what's the average increase blended between the basic and the Medicare plans, the year-over-year increase?

HEALTH POLICY RESEARCH DIVISION CHIEF McKEEVER: For the HMO -- hold on, Mr. Gillihan, let me go to the actual agenda charts, because I believe it's included Attachment 1. So the total basic change, year over year, is roughly over seven percent. And then -- and this is for Alternative number 1 that I'm referencing. And then for total Medicare, it actually is a decrease of a little more than three percent.

COMMITTEE MEMBER GILLIHAN: So on a blended basis though, do we have a. --

HEALTH POLICY RESEARCH DIVISION CHIEF McKEEVER: If you blend the two, I'm going to guess it's somewhere in the neighborhood of four to five percent.

COMMITTEE MEMBER GILLIHAN: And so the -- my point is that while I appreciate the efforts that you all have made to bring options forward and I think it's a -- it's certainly worthy of discussion, we continue to be concerned about the rising cost of health care, which is not a secret to anybody that's heard this spiel before. And I would just note that the Governor has made various proposals to help rein in the cost of health care that

have been neglected by this Board, and I would encourage us to consider other alternatives going forward to help rein in the cost of what's a very expensive program for employers and our employees.

Thank you.

CHAIRPERSON MATHUR: Mr. Bilbrey.

VICE CHAIRPERSON BILBREY: Thank you, Madam Chair. I would like to make a motion. I move approval of the proposed 2016 health maintenance organization risk-adjusted premium rates for Anthem Blue Cross, Blue Shield of California, Health Net, Kaiser Permanente, Sharp, and UnitedHealthcare inclusive of UnitedHealthcare as the single Medicare carrier as reflected in Attachment 1, and with the addition of an optional dental and vision rider available to contracting agency Medicare retirees. The rider is a retiree direct pay option, and has a cost of $26.32 per member per month.

CHAIRPERSON MATHUR: Thank you. Is there --

COMMITTEE MEMBER TAYLOR: Second.

CHAIRPERSON MATHUR: Motion has been made by Bilbrey, seconded by Taylor.

And just to be clear, that is the motion for Alternative 1.

On the motion?

Mr. Jones.

COMMITTEE MEMBER JONES: Yeah. Thank you, Madam Chair. Yes, I support the motion. I just have one question for Doug. You mentioned that UnitedHealthcare, in terms of their total book of business, have about less than one percent that end up having to pay and then get a reimbursement. And the question I have is for those very few that may end up in that situation, how long does it take to be reimbursed for those expenses?

HEALTH POLICY RESEARCH DIVISION CHIEF McKEEVER: Well, Mr. Jones, I can address how long United has committed to reimburse our members in general.

COMMITTEE MEMBER JONES: Yes, that's what I'm concerned about.

HEALTH POLICY RESEARCH DIVISION CHIEF McKEEVER: And that is within 30 days. Now, predicated upon receiving all of the necessary paperwork and everything that they need to validate it, but they've committed to 30 days.

COMMITTEE MEMBER JONES: Thank you.

CHAIRPERSON MATHUR: Thank you.

Mr. Boyken.

ACTING COMMITTEE MEMBER BOYKEN: So we keep referring to this as single. And I get the rationale for that, but, you know, we have options -- five options for Medicare plans, the PPOs, and Kaiser as well. But then I

also had a question, you keep mentioning the possibility of PPO members coming into the United product. Why would they not do that? If you look just on a premium basis -- is there some advantage of staying with the PPO or is that just people don't like to make moves.

HEALTH POLICY RESEARCH DIVISION CHIEF McKEEVER: Mr. Boyken, I think it's just because this has never been offered before to the PPO members who reside in rural counties where there's currently not an HMO Medicare benefit available. So I think what we may find is during open enrollment we may find a lot of our PPO members moving to this product, now that it's offered in a lot of the rural counties, where it typically you're not going to find such a product.

ACTING COMMITTEE MEMBER BOYKEN: Thank you.

CHAIRPERSON MATHUR: I think it would be a good idea. I know we're going to have very extensive communication plan, but to the extent that we can highlight, you know, the advantages -- or the differences between the two plans, I think it's going to come out that the United plan has a lot of advantages over the PPO plan, but that would be helpful in helping people to make their -- an appropriate decision for them.

Okay. I see no further requests to speak. There's a motion on the table.

All those in favor, say aye?
(Ayes.)
COMMITTEE MEMBER JELINCIC: Any public comment?
CHAIRPERSON MATHUR: There is no public comment requested.
So all those in favor say aye?
(Ayes.)
CHAIRPERSON MATHUR: All those opposed?
Any abstentions?
Motion passes.
We'll now move on to Agenda Item number 7, the 2016 PPO plan benefits.
HEALTH POLICY RESEARCH DIVISION CHIEF McKEEVER:
So, Madam Chair, members of the Committee, I'm not going to go through in detail relative to all of the cost and health care dynamics that faced us. It faced us also on the PPO side. So at this point, staff recommends the Committee approve the adoption of the 2016 proposed rates for the PPO plans, the exclusive provider organization, PERS Select, PERS Choice, and PERSCare as contained in Attachment 1 and 2.
CHAIRPERSON MATHUR: This is an action item. What's the pleasure of the Committee?
COMMITTEE MEMBER TAYLOR: Motion.
ACTING COMMITTEE MEMBER BOYKEN: Second.

CHAIRPERSON MATHUR: Moved by Taylor, seconded by Boyken.

Any discussion on the motion?

We do have -- or, sorry, we do have one member of the public who wishes to speak.

Mr. Linn.

And please identify yourself and your affiliation for the record. And you will have three minutes to speak.

MR. LINN: Yes. My name is George Linn and I'm the President of the Retired Public Employees Association.

Madam Chair and Committee members, my concern is we represent a lot of contract agency people. And as I look at these rates, it really seems that when we chop up the State into little bits and pieces, a lot of people have premiums that I think are excessive. I understand some of the philosophy behind trying to keep the people in Southern California happy by having low rates, but we, and myself who live in Northern California, find that we're carrying a greater burden than they are. And I think that this is something that needs to be addressed.

Mr. McKeever briefly mentioned that this is something that might be looked at in the future, but, you know, this has been going on and on. And I think that, you know, we have counties that want to move from one place to the other because they're going to save this much

money, and so the Board has to decide whether or not that's appropriate to shift those people from one group to the other. And I just think this is something that needs more attention and a more creative approach.

Thank you.

CHAIRPERSON MATHUR: Thank you for your comments.

Okay. Any further -- I see no further requests to speak, either from the public or the Board -- or the Committee.

So on the motion, all those in favor?

(Ayes.)

CHAIRPERSON MATHUR: All those opposed?

Any abstentions?

Motion passes.

Move on to Agenda Item number 8, approval of the 2016 association plans rates.

Mr. McKeever.

HEALTH POLICY RESEARCH DIVISION CHIEF McKEEVER:

This is required by Government Code Section 22850(g). And staff recommends the Committee approve the 2016 rates for the California Association of Highway Patrolmen Health Benefits Trust, the California Correctional Peace Officers Association Benefit Trust, and the Peach Officers Research Association of California Insurance Benefits Trust as contained in Attachment 1.

CHAIRPERSON MATHUR: On the -- Mr. Jones.

COMMITTEE MEMBER JONES: Yeah, I have one question. Thank you, Madam Chair. The rates for the associations, you don't -- CalPERS doesn't negotiate those rates, right? That's totally --

HEALTH POLICY RESEARCH DIVISION CHIEF McKEEVER: No, sir, Mr. Jones. This is independent of any activity that CalPERS undertakes. They have boards and they negotiate those through their own collective boards.

COMMITTEE MEMBER JONES: And so what's the purpose of them coming to us?

HEALTH POLICY RESEARCH DIVISION CHIEF McKEEVER: We are statutorily required to bring this to you for approval.

COMMITTEE MEMBER JONES: Okay. With that, I move staff's recommendation

(Laughter.)

CHAIRPERSON MATHUR: Motion has been made by Mr. Jones. Any -- is there a second?

COMMITTEE MEMBER TAYLOR: Second.

CHAIRPERSON MATHUR: Seconded by Ms. Taylor.

Any discussion on the motion?

Seeing none.

All those in favor say aye?

(Ayes.)

CHAIRPERSON MATHUR: All those opposed?

Motion passes.

Move on to -- now we move to the information agenda items. Number 9, State Annuitant Contribution Formula.

Mr. McKeever.

HEALTH POLICY RESEARCH DIVISION CHIEF McKEEVER:

Madam Chair, Members of the Committee, this is an information item only. And as a result of the approval of the HMO and PPO rates for 2016, the State annuitant contribution, which is calculated based on the weighted average of the four health plans with the largest membership is reflected in Attachment 1.

CHAIRPERSON MATHUR: Thank you. Any questions or comments from the Committee?

Seeing none.

That brings us to Agenda Item number 10, which is public comment. I have no requests from the public, but is there anyone who wishes to speak at this time?

Seeing none, we are adjourned. Thank you, everyone.

(Thereupon the California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee open session meeting adjourned at 2:15 p.m.)

C E R T I F I C A T E O F R E P O R T E R

I, JAMES F. PETERS, a Certified Shorthand Reporter of the State of California, do hereby certify:

That I am a disinterested person herein; that the foregoing California Public Employees' Retirement System, Board of Administration, Pension & Health Benefits Committee open session meeting was reported in shorthand by me, James F. Peters, a Certified Shorthand Reporter of the State of California;

That the said proceedings was taken before me, in shorthand writing, and was thereafter transcribed, under my direction, by computer-assisted transcription.

I further certify that I am not of counsel or attorney for any of the parties to said meeting nor in any way interested in the outcome of said meeting.

IN WITNESS WHEREOF, I have hereunto set my hand this 22nd day of June, 2015.

JAMES F. PETERS, CSR
Certified Shorthand Reporter
License No. 10063